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	175277	A. BUILDING _____ B. WING _____	C 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	**1501 INVERNESS DR LAWRENCE, KS 66047**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS70813 and 70903. A revised copy of the deficiencies was sent to the facility on 1/10/14.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 107 residents with 3 residents sampled for falls. Based on observation, interview and record review, the facility failed to accurately assess and reflect 1 (#1) resident's falls on the Minimum Data Set 3.0 assessment.

Findings included:

- The closed record for resident #1 contained a Physician's Order Sheet (POS) dated 12/1/13 which included the diagnoses: hypertension (elevated blood pressure), Parkinson's (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), sundowners (a condition in which a person tends to become confused or disoriented toward the end of the day), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), agitation (excessive chronic restlessness), dementia (progressive mental disorder characterized by failing memory, confusion), and fractured pelvis (broken bone in the pelvis).

The admission Minimum Data Set 3.0 assessment (MDS) dated 4/25/13 documented the Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident's cognitive status was severely impaired. The MDS further documented the resident required extensive assistance of 1 staff with bed mobility, locomotion on unit, dressing, toilet use and personal hygiene. The MDS further documented the resident did not have a history of falls.

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The 30 day Medicare required MDS dated 5/15/13 documented the resident with no falls. The clinical record revealed on 5/6/13 at 8:00 P.M. the staff found the resident on the bathroom floor.
The clinical record revealed on 5/10/13 at 7:50 P.M. the staff found the resident on the bathroom floor.

The quarterly MDS dated 7/26/13 documented the resident with no falls. The clinical record revealed on 6/10/13 at 6:15 A.M. the staff found the resident on the floor of his/her room.

The quarterly MDS dated 10/24/13 documented the resident with no falls. The clinical record revealed on 8/10/13 at 10:00 P.M. the staff found the resident on the floor of his/her room.

On 12/19/13 at 8:30 A.M. administrative nursing staff E revealed the falls were not documented on the MDS's. The resident did have falls during the look back period for each of the MDS's.

On 12/19/13 at 8:45 A.M. administrative nursing staff D revealed the MDSs lacked documentation related to falls.

The 7/18/12 facility policy "MDS 3.0" documented the assessment system provided a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident's functional capabilities and helped staff to identify health problems. The attestation statement of accuracy should be signed by each discipline that completed a section of the MDS.

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F 278	Continued From page 3 The facility failed to accurately assess and reflect the resident's falls on the MDS assessment.	F 278		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 107 residents with 3 residents sampled for falls. Based on observation, interview and record review, the facility failed to provide timely and effective interventions to prevent falls for 3 of 3 residents sampled (#1, #2, #3) resulting in injuries for 2 residents. Findings included: - Resident #3's Physician Order Sheet (POS) dated 12/1/13 included the diagnoses: urinary tract infection (UTI) and syncope (temporary loss of consciousness). The annual Minimum Data Set Assessment 3.0 (MDS) dated 8/15/13 documented the resident with short term memory problem and moderately impaired decision making skills. The MDS further documented the resident required extensive assistance of 2 staff with transfers and extensive assistance of 1 staff with bed mobility, dressing,	F 323		

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toilet use and personal hygiene. The resident's balance was not steady and only able to stabilize with staff assistance. The MDS further documented the resident had 2 or more falls with no injuries.

The quarterly MDS dated 11/14/13 revealed the Brief Interview for Mental Status (BIMS) score of 2 which indicated severs cognitive impairment.

The fall Care Area Assessment (CAA) dated 8/29/13 documented the resident required assistance with transfers and toileting. The resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The revised care plan dated 11/25/13 identified the resident at risk for falling related to a recent hospitalization for syncope episode on 10/16/13 and documented the following approaches: an alarm on the bed and the wheelchair to alert the staff when the resident begun to stand up, provide slip resistant socks when in the bed, give the resident verbal reminders not to ambulate/transfer without assistance, Dycem (material used to prevent sliding) on the wheelchair cushion to prevent sliding out of the wheelchair, the resident would attempt to get off the toilet by self, please stay with the resident in the bathroom when toileting, keep the call light in reach at all times, keep personal items and frequently used items within reach, please let the resident stay in the dining room as long as he/she wished, wake the resident if he/she fell asleep at the table, provide proper, well-maintained footwear, provide the resident an environment free of clutter, and provide toileting assistance every 2 to 4 hours and as needed. Approaches

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added on 10/16/13 included to educate the staff on the toileting plan. Approach added on 10/23/13 included to place Dycem in the wheelchair.

Review of the clinical record related to falls revealed the following:
On 1/23/13 at 3:20 P.M. the resident had a fall and staff initiated vital signs per the facility's policy. Staff added Dycem to the recliner to hold the alarm in place.

On 4/1/13 at 10:10 A.M. the resident was lowered to the floor by staff while toileting the resident, the resident's feet got tangled between the toilet riser and the wheelchair and the resident lost his/her balance. The resident received no injuries. The staff initiated the intervention to provide a safe environment.

On 4/12/13 at 10:55 A.M. the resident was in the bathroom at the sink brushing his/her teeth and the resident slid off the seated walker onto his/her bottom. The resident received no injuries. The staff placed Dycem on the walker seat and educated the resident, the staff must be present when sitting on the walker seat.

On 6/30/13 at 8:41 P.M. the staff found the resident sitting on the bathroom floor next to the sink. The resident received no injuries. Staff referred the resident to physical therapy. The care plan listed the interventions for an alarm to the bed and wheel chair initiated on 6/30/13.

On 7/27/13 at 6:19 A.M. staff heard an alarm going off at 4:15 A.M. and found the resident sitting on the bathroom floor next to the sink. The resident received no injuries. The staff initiated the intervention for nonskid socks when in bed.

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On 10/16/13 at 8:00 P.M. the staff reported the resident had fallen in his/her room. The resident's right wrist/hand/arm areas were swollen and very painful with movement. The physician ordered an x-ray of the right wrist and to send the resident to the emergency room if a fracture was seen. The X-ray results showed a fracture of right radius and ulna bones in the wrist and the resident was sent to the hospital. Staff educated the resident and the staff, and the staff needed to assist the resident when in the bathroom (already listed on the 5/24/13 care plan.

On 12/19/13 at 8:10 A.M. the resident sat in a wheelchair in the dining room, dozing off and on. The nursing staff would encourage the resident to eat and he/she would take a small bite and doze off again.

On 12/19/13 at 3:15 P.M. direct care staff O revealed the resident had alarms on his/her wheelchair and the bed. Direct care staff O revealed the resident was a fall risk and staff had to remind (the cognitively impaired) resident to wait for assistance. The nursing staff should make sure the walker and wheelchair were not within the resident's reach or the resident would attempt to get up by him/herself.

On 12/19/13 at 3:25 P.M. licensed nursing staff I revealed the (cognitively impaired) resident wanted to remain as independent as possible, so alarms were on the wheelchair and the bed to alert the staff when he/she would try to get up by his/herself. The resident could be quick so the nursing staff had to watch him/her closely. The resident had a fall in the bathroom and broke his/her wrist recently. The doctor removed the

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cast and the resident was trying to do activities of daily living and we had to remind him/her to wait for the staff to assist.

On 12/19/13 at 5:30 P.M. administrative nursing staff D revealed the resident recently had a fall which resulted in a fractured wrist. Administrative nursing staff D revealed the resident tried to do as much as possible without assistance.

The 10/15/11 facility policy "Fall Management and Investigation Program" documented the facility would utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assuasive devices and interventions to manage and minimize falls and identify the resident's continued needs. The care plan's fall intervention was reviewed for continued effectiveness. The interventions were revised as indicated by the incident and current resident needs. The revised interventions were routinely reviewed and updated to ensure effectiveness. The interventions would be reviewed with the staff, family and resident for compliance.

The facility failed to reassess and implement effective interventions to prevent falls for this cognitively impaired resident that required extensive assistance with activities of daily. The resident had 6 falls in the last year and 1 fall resulted in a fractured wrist.

- The closed record for resident #1 contained a Physician's Order Sheet (POS) dated 12/1/13 which included the diagnoses: hypertension (elevated blood pressure), Parkinson's (a slowly progressive neurologic disorder characterized by

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resting tremor, rolling of the fingers, mask-like faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), sundowners (a condition in which a person tends to become confused or disoriented toward the end of the day), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), agitation (excessive chronic restlessness), dementia (progressive mental disorder characterized by failing memory, confusion), and fractured pelvis (broken bone in the pelvis).

The admission Minimum Data Set 3.0 assessment (MDS) dated 4/25/13 documented the Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident's cognitive status was severely impaired. The MDS further documented the resident required extensive assistance of 1 staff with bed mobility, locomotion on the unit, dressing, toilet use and personal hygiene. The MDS further documented the resident did not have a history of falls.

The 30 day Medicare required MDS dated 5/15/13 documented the resident with no falls. The medical record revealed the resident had a fall on 5/6/13 and 5/10/13.

The quarterly MDS dated 7/26/13 documented the resident with no falls. The medical record revealed the resident had a fall on 6/10/13.

The quarterly MDS dated 10/24/13 documented the resident with no falls. The medical record revealed the resident had a fall on 8/10/13.

The Fall Care Area Assessment (CAA) dated 5/1/13 documented the resident was admitted

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with a diagnosis of weakness and debility (state of weakness). The resident had cognitive loss due to the diagnoses of Parkinson's and dementia. The resident required extensive assistance with activities of daily living (ADLs).

The initial care plan dated 4/19/13 related to falls documented the resident was at a moderate risk for falls according to the Fall Risk Review Tool related to weakness. The approaches included a referral to physical therapy, occupational therapy and restorative, the call light to be usable and within reach, the bed in the lowest position, keep the room free from clutter, ensure the resident wore proper foot wear, equipment needed included a wheelchair, a floor mat by the bed, an alarm while in the chair and/or the bed, and all staff informed of the resident's fall risk.

Review of the clinical record related to falls revealed the following:
On 5/6/13 at 8:00 P.M. the resident was found on the bathroom floor. The resident was trying to transfer self to the toilet, fell and received no injuries. The staff initiated the intervention to toilet the resident before and after meals, before going to bed, and when the resident woke up at night.

On 5/10/13 at 7:50 P.M. the resident was found on the bathroom floor. The resident was trying to go to the bathroom and slipped out of his/her chair and received no injuries. The staff initiated the intervention to encourage the resident to turn on his/her call light and to ask for assistance to the bathroom.

On 6/10/13 at 6:15 A.M. the resident was found on the floor of the bedroom with a bed alarm

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sounding. The resident stated he/she had fallen when he/she got up to go to the bathroom. The resident received 2 abrasions to his/her left elbow and complained of pain in his/her right axillary region. The staff added the intervention to have the resident wear nonskid socks to bed.

On 6/17/13 at 12:02 P.M. the resident verbalized pain in the right axillary region and upon observation noted a large blue/yellow bruise to right axillary/breast area.

The care plan reviewed on 7/29/13 revealed the resident was at risk for falls. The approaches included to anticipate the resident's needs; like bathroom issues, eating and grooming, keep the call light within reach and answer the call light when the resident turned the call light on, remind the resident to call for assistance with any needs, use adaptive equipment as the resident needed, and to use the safety devices as ordered to help with his/her safety.

On 8/10/13 at 10:00 P.M. the resident observed on the bedroom floor between the bed and the wheelchair. The resident stated he/she fell out of the bed, and received no injuries. Staff referred the resident to the rehabilitation department for a screening.

On 11/1/13 at 8:15 P.M. the resident was found lying on the floor in the living room on his/her right side. The resident received no injuries. Staff added the intervention for staff to increase activities during periods of agitation.

On 11/9/13 at 8:15 P.M. the resident was found on floor in his/her room between the bed and wheelchair with his/her head against the bedside

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table. The resident stated he/she hit their head really hard and his/her head really hurt. The resident's pupils were non-reactive. The resident was sent to the emergency room for evaluation and returned at 11:50 P.M. with no new orders. The staff again referred the resident to occupational therapy for a screening.

On 11/25/13 at 00:30 A.M. the resident's bed alarm sounded and staff found the resident on the floor beside his/her bed laying on his/her left side. Staff assisted the resident to an upright position and the resident was unable to bear weight. The resident was transferred to the hospital by ambulance for evaluation of possible fracture. The resident returned to the facility on 11/29/13 with fracture of the left sacral process and left inferior pubic ramus (pelvic bone) from the fall, probably related to osteoporosis/pathologic fracture (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and a left inguinal hernia repair related to an obstruction. Staff added the intervention for body pillows while in bed. Staff added the intervention for body pillows while in the bed.

On 11/30/13 at 9:00 P.M. staff found the resident on the floor in front of the toilet lying on his/her right side. The resident received a laceration above the right eye. Staff unable to obtain vital signs, resident transferred to the hospital by ambulance for evaluation of head injury. The resident returned on 11/30/13 at 10:30 P.M. with the diagnosis of a laceration/abrasion over the right eyebrow. Staff added the intervention to stay with the resident during toileting.

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On 12/19/13 at 8:08 A.M. licensed nursing staff H revealed when a resident had a fall, nursing does a head to toe assessment to check for any injuries. Nursing would investigate to find the cause of the fall and place interventions to prevent further falls.

On 12/19/13 at 3:15 P.M. direct care staff O revealed the residents who were a fall risk usually had alarms and when the staff heard the alarms, the resident had to be check on to make sure the resident had not fallen. The resident was encouraged to use the call light and to wait for the staff to help them so they would not fall.

On 12/19/13 at 5:45 P.M. administrative nursing staff D revealed the resident received a fracture from a fall, which was not surgically repaired, but while in the hospital the resident had surgery for a hernia repair. When the resident returned from the hospital he/she received hospice services. Administrative nursing staff D revealed the facility does not do fall risk assessment on the residents.

The 10/15/11 facility policy "Fall Management and Investigation Program" documented the facility would utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assistive devices and interventions to manage and minimize falls and identify the resident's continued needs. The care plan's fall intervention was reviewed for continued effectiveness. The interventions were revised as indicated by the incident and current resident needs. The revised interventions were routinely reviewed and updated to ensure effectiveness. The interventions would be reviewed with the staff, family and resident for compliance.

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The facility failed to reassess and develop and implement appropriate interventions to prevent falls for this cognitively impaired resident with a history of 8 falls in 7 months which resulted in 3 hospital visits with a fracture and 2 hospital emergency room visits for head injuries, loss of consciousness and a laceration.

- Resident #2's Physician's Order Sheet (POS) dated 11/1/13 included the diagnoses: frequent falls, dysphagia during oropharyngeal phase (difficulty with swallowing in the mouth and the tube in the back of the mouth), Parkinson's (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), neuro degenerative disorder (deterioration in the function of the nervous system), and progressive supranuclear palsy (characterized by staring facial expression, eye dysfunction, dementia -progressive mental disorder characterized by failing memory, confusion and progressive spasticity).

The admission Minimum Data Set Assessment 3.0 (MDS) dated 1/28/13 revealed the Brief Interview for Mental Status (BIMS) score of 14 which indicated no cognitive deficits. The MDS further documented the resident required limited assistance of 1 staff with bed mobility, toilet use, and personal hygiene, and supervision with set up help for transfers, walking, dressing, and eating. The MDS further documented no falls.

The quarterly MDS dated 4/30/13 documented

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	175277	A. BUILDING _____ B. WING _____	C 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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the resident required supervision with set up for all activities of daily living and history of 2 or more falls with no injury.

The 7/31/13 and 10/31/13 quarterly MDSs documented the resident with 2 or more falls with no injuries.

The fall Care Area Assessment (CAA) dated 1/31/13 documented the resident was at risk for falls due to the diagnosis of Parkinson's disease. The resident ' s balance was unsteady but the resident was able to steady self without staff assistance.

Review of the clinical record related to falls revealed the following:
On 5/5/13 at 5:40 P.M. staff observed the resident in the dining room after the evening meal, stand up from the table, pushed in the dining room chair and fell onto his/her buttocks and received no injuries. Staff educated the resident to exit the side of the chair the walker was on and to let the staff push the chair up to the table.

On 5/7/13 at 1:00 P.M. the resident fell in the hallway and received no injuries. The care plan listed the intervention for staff to watch for orthostatic hypertension and obtain orthostatic (related to upright position) blood pressures to screen for changes upon standing prior to ambulation.

On 5/9/13 at 3:10 P.M. staff found the resident sitting on his/her bottom in front of the bed with a walker in front of him/her. The resident did not receive any injuries. Staff educated the resident to use the call light to ask for help before

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repositioning.

On 5/10/13 at 10:45 A.M. staff found the resident on the floor in his/her room and the resident did not receive any injuries. Staff repeated the 5/7/13 intervention to check orthostatic blood pressures.

On 5/15/13 at 12:30 P.M. staff found the resident on the floor in the bathroom next to the toilet and received no injuries. Staff placed nonskid tape in front of the resident's toilet. Staff added the intervention to the care plan to check orthostatic (related to upright position) blood pressures.

A physician note dated 6/4/13 listed the resident had frequent falls and the physician had asked the facility to provide full assist with transfers "numerous times" to avoid further falls as this is the reason the resident was placed in nursing care.

On 9/2/13 at 00:02 A.M. staff found the resident on the floor and the resident received no injuries. Staff added the intervention to keep the bed in the low position when the resident was in the bed.

On 9/8/13 at 9:20 A.M. staff found the resident on the floor beside the bed with his/her back next to the bedside table. The resident did not receive any injuries. Staff added a fall mat beside the bed and placed a personal alarm.

On 10/23/13 at 12:18 P.M. staff found the resident on the floor at 10:30 A.M. with his/her head resting on the floor mat and his/her buttocks up in the air. The resident did not receive any injuries. Staff added the intervention for the resident to use a grabber to reach for items on the floor.

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On 10/31/13 (untimed entry) an alarm sounded and staff found the resident on the floor beside the wheelchair. The resident did not receive any injuries. Staff added foot pedals on the wheelchair but discontinued it on 11/7/13.

The updated care plan dated 11/7/13 revealed the resident was at risk for falls. The approaches included: to anticipate the resident's needs like bathroom issues, eating and grooming, keep the call light within reach and answer the call light when turned on, remind the resident to call for assist with any needs, use adaptive equipment as needed, and to use safety devices as ordered to help with his/her safety.

On 11/12/13 at 8:15 P.M. staff found the resident on the floor in the bathroom. The resident did not receive any injuries. Staff referred the resident to therapy and obtained a urine analysis.

On 11/17/13 at 1:30 P.M. the chair alarm sounded and staff found the resident sitting on the floor in the bathroom. The resident did not receive any injuries. Staff put a reminder sign in the bathroom, referred to occupational therapy, and restorative staff to work with the resident.

On 12/5/13 at 2:45 P.M. the resident raised the bed to the highest position and then the resident slid off the bed onto the floor. The resident did not receive any injuries. The staff obtained another therapy referral. The Rehabilitation Referral Form revealed the referral was for use of the bed control. The therapist referred the resident to restorative, but the reason or interventions for restorative not listed. The form was not signed or dated by the staff assessing

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the resident.

On 12/10/13 at 9:30 P.M. staff found the resident sitting on the floor in front of his/her wheelchair and the bed. The resident did not receive any injuries. Staff added the intervention to increase activities for the resident.

On 12/13/13 at 9:15 P.M. staff was taking the resident to the bathroom and the resident reached forward as if to grab the railing and tumbled out of the wheelchair. The resident did not receive any injuries. The staff asked for another occupational therapy referral. The facility provided Rehab Referral and Screen Outcome Form dated 12/16/14 (13) listed the resident had a recent fall and requested an evaluation for the use of the sit to stand lift. This form lacked evidence the therapist had evaluated the resident.

On 12/16/13 at 6:30 A.M. staff found the resident lying on his/her left side on the floor mat beside the bed. The resident did not receive any injuries. The record lacked evidence the facility added additional interventions.

On 12/19/13 at 9:25 A.M. the resident sat in a wheelchair in his/her room with a personal alarm attached to the wheelchair. A fall mat was in place next to the resident's bed. Clothing items were thrown on the floor. The resident was unable to verbalize and refused to nod to yes or no questions.

On 12/19/13 at 3:15 P.M. direct care staff O revealed the resident could be difficult at times and would not let the staff help him/her. The resident had falls due to non-compliance, such as not wanting or waiting for help.

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F 323	Continued From page 18 On 12/19/13 at 3:25 P.M. licensed nursing staff I revealed the resident had behaviors of non-compliance such as not waiting for assistance, not using assistive devices, throwing items on the floor and refusing to let nursing pick the items up. On 12/19/13 at 5:30 P.M. administrative nursing staff D revealed the resident had a lot of falls but he/she refused to wait for help. Administrative nursing staff D revealed the facility did not do fall risk assessments. The 10/15/11 facility policy "Fall Management and Investigation Program" documented the facility would utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assistive devices and interventions to manage and minimize falls and identify the resident's continued needs. The care plan's fall interventions were reviewed for continued effectiveness. The interventions were revised as indicated by the incident and current resident needs. The revised interventions were routinely reviewed and updated to ensure effectiveness. The interventions would be reviewed with the staff, family and resident for compliance. The facility failed to reassess and develop and implement effective interventions to prevent falls for this resident that had 14 falls in a 7 month period.	F 323		